18640 E. 38th Terr. S.
Independence, MO
64057

206 N.W. Mock Ave.
Suite 100
Blue Springs, MO 64014

JACKSON COUNTY
GASTROENTEROLOGY

**Gregory M. Vardakis, DO Farid M. Namin, MD**
**Johnna Bodenstab, FNP-BC Kathleen Steensma, FNP-C**

*Specializing in the Diagnosis and Treatment of Diseases of the Digestive Tract, Liver, Pancreas, and Gallbladder*

Office:
816-229-1191
Fax:
816-229-1198

# MEDICAL HISTORY

**TODAY'S DATE:** _____/_____/_____ ❑ **NEW PATIENT** ❑ **UPDATE**

**NAME:** Mr. /Mrs. /Ms. _____ **DATE OF BIRTH**____/____/____
LAST FIRST MIDDLE NAME

**REFFERING PROVIDER:** _____ **PRIMARY CARE PROVIDER**: _____

**CURRENT GASTROINTESTINAL CONDITIONS:** *List all that apply to today's visit*

_____

_____

**DRUG ALLERGIES:**

_____ _____ _____ _____

**PAST MEDICAL ILLNESSES** *(Check all that apply):*

**Gastrointestinal Conditions-**

| | | | | |
|---|---|---|---|---|
| ❑ Acid Reflux | ❑ Colon Polyps | ❑ Gallbladder Disease | ❑ Hiatal Hernia | ❑ Small bowel bacteria overgrowth |
| ❑ Barrett's | ❑ Crohn's Disease | ❑ Gastritis | ❑ H. Pylori | ❑ Ulcerated Colitis |
| ❑ C. Difficile | ❑ Diverticulitis | ❑ Hemorrhoids | ❑ Irritable Bowel Syndrome | ❑ Yellow Jaundice |
| ❑ Celiac Disease | ❑ Diverticulosis | ❑ Hepatitis B | ❑ Liver Disease | ❑ NONE |
| ❑ Cirrhosis | ❑ Esophageal Stricture | ❑ Hepatitis C | ❑ Pancreatitis | |

❑Other: _____

**Non-Gastrointestinal Conditions** *(Check all that apply):*

| | | | |
|---|---|---|---|
| ❑ Anemia | ❑ Congestive Heart Failure | ❑ Heart Attack | ❑ Parkinson's Disease |
| ❑ Anxiety | ❑ COPD | ❑ Heart Disease | ❑ Rheumatic Fever |
| ❑ Asthma | ❑ Dementia | ❑ High Blood Pressure | ❑ Sleep Apnea |
| ❑ Bleeding Disorder | ❑ Depression | ❑ Kidney Disease | ❑ Stroke |
| ❑ Blood Clot | ❑ Diabetes | ❑ Lupus | ❑ NONE |

❑Other: _____

**SURGICAL HISTORY:**

_____ _____ _____ _____

_____ _____ _____ _____

**Have you ever had any GI Procedures**? (*Please indicate yes or no to the following procedures)*

❑ Colonoscopy: ❑ **Yes** ❑ **No** Date: _____ Location: _____ Performed by Dr._____

❑ Upper Endoscopy: ❑ **Yes** ❑ **No** Date: _____ Location: _____ Performed by Dr._____

**FAMILY HISTORY** *(Check all that apply and note relative and age):*

❑Acid Reflux_____ ❑Cirrhosis_____ ❑Colon Polyps_____ ❑Crohn's Disease_____

❑Diverticulitis_____ ❑Liver Disease_____ ❑Pancreatitis_____ ❑Ulcers_____ ❑Ulcerative Colitis _____

❑Other: _____

**CANCERS:** ❑ Esophagus_____ ❑ Colon_____ ❑ Liver_____ ❑ Pancreatic_____ ❑Stomach_____

❑ Other _____

**SOCIAL HISTORY:**

❑ Tobacco Use ❑ Yes ❑ No How Much? _____ How Long? _____

❑ Alcohol Use ❑ Yes ❑ No How Much? _____ How Long? _____

**IMMUNIZATION HISTORY:** *(Please list dates of most recent vaccinations)*

Hepatitis A: _____ Hepatitis B: _____ Influenza: _____

Pneumonia: _____ Tetanus: _____ Other: _____

**WOMEN:**

When was your last period? : _____ Are you Pregnant: ❑ Yes ❑ No ❑ Maybe

Number of Pregnancies: _____ Number of Births: _____ Number of Miscarriages: _____

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## PATIENT INFORMATION

**DATE OF VISIT: _____/_____/_____**  ❑ **NEW PATIENT** ❑ **UPDATE**

**Patient: NAME**: Mr./Mrs./Ms. _____ **Date of Birth** _____/_____/_____
LAST FIRST MIDDLE NAME

**ADDRESS**: _____
STREET CITY STATE ZIP

**PHONE NUMBERS: HOME**: _____ **WORK**: _____ MOBILE: _____

**SOCIAL SECURITY #:** _____ **MARITAL STATUS:** S / M / W / D **EMAIL:** _____

**PHARMACY:** _____ **PHONE:** _____

**Spouse/Emergency Contact Information:**

**NAME**: Mr. /Mrs. /Ms. _____ **Date of Birth** _____/_____/_____
LAST FIRST MIDDLE NAME

**ADDRESS**: _____
STREET CITY STATE ZIP

**PHONE NUMBERS: HOME**: _____ **WORK**: _____ MOBILE: _____

**Additional Emergency Contact:**

**NAME**: _____ **RELATIONSHIP**_____ **PHONE:**_____
LAST FIRST

## MEDICAL INSURANCE INFORMATION

**Guarantor/Policy Holder Information:** ❑ Same as patient

**NAME**: Mr. /Mrs. /Ms. _____ **Date of Birth** _____/_____/_____
LAST FIRST MIDDLE NAME

**ADDRESS**: _____
STREET CITY STATE ZIP

**PHONE NUMBERS: HOME**: _____ WORK: _____ MOBILE: _____

**SOCIAL SECURITY #:** _____ EMPLOYER: _____

**PHONE NUMBERS: HOME**: _____ WORK: _____ MOBILE: _____

| **PRIMARY INSURANCE** | **SECONDARY INSURANCE** |
|---|---|
| **COMPANY NAME**: _____ | **COMPANY NAME:** _____ |
| **POLICY #:** _____ | **POLICY #:** _____ |
| **GROUP #:** _____ | **GROUP #:** _____ |
| **POLICY HOLDER/DOB**:_____ | **POLICY HOLDER/DOB:**_____ |
| **RELATION TO PATIENT:** _____ | **RELATION TO PATIENT:** _____ |
| **POLICY HOLDER SSN:**_____ | **POLICY HOLDER SSN**:_____ |

**Other than the referring/consulting Health Care Provider, please list anyone you authorize the disclosure of your medical or financial information (test results, copy of billing history, confirming appointment etc) to:**

**NAME:**_____ **RELATIONHIP:**_____ **PHONE:**_____

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# NOTICE OF PRIVACY PRACTICES

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully:***

We are required by law to provide you with this notice that explains our privacy practices about your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

**Ways in which we may use and disclose your protected health information:**

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive.

**Treatment.** We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We may also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example- we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

**Payment.** We may use and disclose your protected health information to obtain payment for the health care services we provide you. For example- We may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

**Health Care Operations.** We may use and disclose your protected health information to support the business activities of our practice. For example- We may use medical information about you to review and evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

**Other Ways We May Use and Disclose Your Protected Health Information:**

**Appointment Reminders.** We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

**Treatment Alternatives.** We may use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

**Others Involved In Your Care.** We may use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

**Research.** We may use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that had reviewed the research proposal and established protocols to ensure the privacy of your health information.

**An accounting of disclosures.** You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, and for health care options. Your request must be made in writing & must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) or for a period of time greater that six years (our legal obligation to retain information).

Your first request for a **list of disclosures** within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

**Request Confidential Communications.** You have the right to request how we communicate with you to preserve your privacy. For example- You may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

**File a complaint.** If you believe we have violated your medical information privacy rights, you have the right to file with Dr. Vardakis directly to the Secretary of Health and Human Services.

To file a complaint with this office, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and mail it to this office. You should know there would be no retaliation for your filling a complaint.

**Payment.** We may use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

**To Avert a Serious Threat to Public Health or Safety.** We may use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we may also disclose your health information to a foreign government agency that is collaborating with the public health authority.

**Worker's Compensation.** We may use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work related injuries or illness.

## Your Health Information Rights

Although your health records are the physical property of the health care practitioner or facility that compiled it, the information is of you.

You have the right to:

**A Paper Copy of This Notice.** You have the right to receive a paper copy of this notice upon written request. We may charge a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. Please visit the official State of Missouri's website for the *Missouri Revised Statutes* current fees for copying records.

**Inspect.** You have the right to inspect the protected health information that we generate about you as long as we maintain the original information. This information includes your medical and billing records, as well as any other records we generate for to make decisions about you. Any psychotherapy notes that may have been included in records we receive about you are not available for your inspection or copying by law. If you wish to inspect your medical information, you submit your request in writing to this office. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

**Request Amendment.** You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to this office, stating exactly what information is incomplete or inaccurate and you're reasoning that support your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

-the information was not created by us, or the person who created it is no longer available to make the amendment;

-the information is not part of the record that you are permitted to inspect and copy;

-the information is not part of the designated record set kept by this practice: or it is the opinion of the health care provider that the information is accurate and complete.

**Request Restrictions.** You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example- you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our office manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

## Uses or Disclosures Not Covered

Uses or disclosures of your information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization.

## For More Information

If you have any questions or would like additional information, you may contact our office at

816-229-1191

**As a final note, your privacy has always been a primary concern in this office. Let me assure you that my office staff and I intend to maintain the highest standards of patient-doctor confidentiality. –Greg Vardakis, D.O.**

Effective date: 4/14/2003

Mail all correspondence to:

*JACKSON COUNTY GASTROENTEROLOGY*

*18640 E 38$^{TH}$ TERR SOUTH*
*INDPENDENCE, MO 64057*

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**Patient Acknowledgement:**

**I, _____, hereby acknowledge I have read and agree to the terms and conditions of this practice and I hereby authorize the release of any medical information necessary to process my health insurance claim form and request payment of benefits to the provider of service. I understand that I am financially responsible to Jackson County Gastroenterology PC for charges not covered or denied by my insurance company. I agree to permit Jackson County Gastroenterology PC and their business associate to contact me and all other responsible parties on my account, with an automated dialing device on our cellphone or other mobile devices concerning any and all aspects of my account; financial, procedural or scheduling. I further agree in the event of non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required. In the event of a missed appointment without a 24 hour notice, you may be subject to a $50 fee. A copy of this document and the signature below shall be treated as an original in my record.**

**X_____ Date: _____**
**Guarantor Signature**
**X_____**
**Printed Name**

**X_____ Date: _____**
**Co-Guarantor Signature**
**X_____**
**Printed Name**